

MEDICAL CLAIM TRANSMITTAL**UnitedHealthcare**
A UnitedHealth Group Company**HANFORD EMPLOYEE WELFARE TRUST**
Group Number: 702633**PO Box 30555**
Salt Lake City, UT 84130-0555
1-866-249-7606**A. MEMBER/EMPLOYEE INFORMATION**

Member # (SSN):		Phone #: ()	
Last Name:	First Name:	MI:	Date of Birth:
Home Address:			New Address: Yes <input type="radio"/> No <input type="radio"/>
City:		State:	Zip Code:
Spouse Last Name:	First Name:	MI:	Spouse Date of Birth:

B. PATIENT INFORMATION

Last Name:		First Name:		MI:	Date of Birth:
Home Address:					
City:			State:	Zip Code:	
Sex: M <input type="radio"/> F <input type="radio"/>	Relationship To Member:	Full Time Student: Yes <input type="radio"/> No <input type="radio"/>	School Name:	School Phone #: ()	

C. ACCIDENT INFORMATION

Work Accident? Yes <input type="radio"/> No <input type="radio"/>	Auto Accident? Yes <input type="radio"/> No <input type="radio"/>	Date Accident Occurred:
How did the Accident Occur:		

D. OTHER INSURANCE

Is the patient covered by another plan?: Yes <input type="radio"/> No <input type="radio"/> If yes, please complete the following	
Name of the person carrying other insurance:	Date of Birth:
SSN #:	Name of Other Insurance Carrier:
Policy Number:	Employer Name:
ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.	
Member Signature: _____ Date: _____	

E. ASSIGNMENT OF BENEFITS

Please sign below <i>only if you want UnitedHealthcare to pay benefits directly to the provider</i> of medical services.	
Member Signature: _____	Date: _____

GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- Clip, do not staple, all bills to the completed form and mail them to UnitedHealthcare at the address above.
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims to UnitedHealthcare in a timely manner.
- Be sure to notify your employer of all address changes.
- Please include your Member Number on all documents.